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DENTIGEROUS CYSTS.

As Essay to which was awarded the First Prize of the Boylston Medical Society for 1871.

By W. P. BOLLES, M.D.

THIS is not an affection which demands our time by its frequency or fatality. Yet its occurrence is sufficiently common to give its study practical interest, and, when present, it requires an intelligent interference to accomplish a cure. Coming, as this tumor does, in the most conspicuous part of the body, it not only encroaches upon the two great cavities of the face and impairs their functions, but thrusts out the lips or cheek, where concealment is impossible, to form an ugly and alarming deformity; and this, too, usually during a period when personal beauty is valued most highly. The surgeon who is familiar with this disease and can eliminate the various growths which simulate it, can promise to his patient not only life and comfort, but a restoration of comeliness. The chief interest of the disease, however, is not in the practical view just mentioned, but involves considerations which include also the structure and development of the organs affected. Dentigerous cysts owe their possibility to these elements, and are therefore peculiar to the jaws; they are extraordinary developments of cavities which, at a certain period of fœtal life, exist normally, and cover the teeth as they lie imbedded in the substance of the maxillary arches; an abnormal action of the secreting power which these cysts possess, in fact causes the disease which we are considering. The cysts are not at all related in their nature to those cavities of other bones with which, until recently, they have been confounded, nor even with certain other cystic troubles of the jaws themselves, from which even now they are scarcely separated. The development of the parts concerned must, therefore, be studied before the disease itself.

Very early in fœtal life, before the human embryo attains an inch in length, even while the nose and mouth are still a common chasm, a thickening of the membrane of the maxillary arches forms a semicircular ridge around their corresponding margins. The epithelium covering this ridge now proliferates, and along the summit of the ridge *several* layers of cells, instead of *one*, are found which indent the underlying substance, dividing the ridge into two ("dental ridges") by a shallow groove ("dental groove"). From the bottom of this groove a narrow epithelial fold grows deeply into the tissues beneath it, and is called the "enamel germ." These changes, according to the more recent observers, appear in the deeper layers of the epithelium only, while the free surface is kept nearly in the same place by the accumulation of its cells. The enamel germ next widens at the bottom, and becomes divided into segments corresponding with the number of the temporary teeth. Each of these divisions, which are called "enamel organs," is somewhat flask-shaped and connected with the groove above by a narrow neck, the relic now of the enamel germ. A papilla, called the "dental germ," soon grows into the enamel organ from below, carrying, as it advances, the floor of the latter upon its summit; clothed with this it projects boldly into the "flask," invaginating its lower half, and there assumes the likeness of a tooth, with the enamel organ, now something of a "meniscus" in shape, resting upon its crown. The narrow isthmus reaching to the surface of the jaw then contracts and disappears, a vascular and fibrous envelop* surrounds the parts described, and is itself encompassed by the ossifying jaw. Thus the tooth is isolated from the mouth and from its fellows, and enclosed in solid bone in most close connection with an equally isolated epithelial sac.†

* "Dental sac." Waldeyer, however, describes this as "richer in cells and vessels," and says that it disappears early.—Stricker's Histology, vol. i. p. 488 (Syd. Soc. Trans.).

† The object of nature in thus enclosing the dental organs seems to be to accomplish the formation of the enamel, for in certain fishes whose development does not

Those cells of the dental germ which lie immediately beneath its surface are next developed into a well-marked layer of bone-forming elements,* by means of which the dentine is produced, and soon forms a thin shell over the crown of the papilla, and increases in thickness, growing toward the centre of the tooth by successive layers of the same "odontoblasts."

Meanwhile, very great changes have taken place in the enamel organ. Its upper wall, but slightly altered, still consists of short and cubical cells. Its interior presents a web of stellate cells, converted from the accumulated epithelium, and widely separated in "a rich albuminous fluid." The layer enveloping the dentine would not now be recognized; its cells have become prismatic, regular and very long, their nuclei have advanced toward their superficial extremities (i. e. next the enamel pulp), their ends appear to be open. It is, however, continuous with the outer wall at its border, and the true epithelial covering of the remarkable papilla beneath it.† An intermediate layer‡ of loose and rounded cells lies between this and the stellate forms in the middle. The enamel begins on the surface of the dentine by the calcification of these prismatic cells and increases outwards (in an opposite direction from the progress of the other), either by their elongation or successive replacement by the rounded ones next to them. Thus the growing enamel encroaches upon the enamel organ and is nourished by it.§ The latter wastes as the other increases, and the tooth advances towards the gum, until finally, the pulpy part disappearing, its upper wall lies upon the surface of the enamel and hardens on it as the "cuticula dentis."—Stricker, op. cit. p. 485.

The cement is formed below the margin of the enamel by the ossification of the dental capsule. ("From the connective tissue of the dental alveoli."—Waldeyer.)

In the course of time the fang developes and elongates, the jaw and gum dissolve before the advancing tooth, and this at last appears in the cavity of the mouth.

From the inner side of the neck of each of the enamel organs which serve the temporary teeth, a second pouch is given off, which afterwards serves the corresponding permanent tooth in a similar course of development. There always remains, however, an unossified cord extending from this capsule, either to the gum or to the socket of the temporary tooth from which it sprung; thought to be a relic of the neck of the enamel organ*—a sort of umbilicus.

The first permanent molar is formed indepently from the milk set, the second from this by the budding process just described for the permanent teeth generally, and the third in like manner from the second. These in this respect resemble three generations of teeth, which, however, do not succeed each other, because the growth of the jaw at this place allows them all to coëxist.†

The growth and eruption of the permanent teeth are governed by the some rules as those of the temporary teeth; the process, however, is embarrassed and rendered difficult by the presence of the latter. The temporary alveoli are invaded by the new teeth; the temporary roots dissolve before them; and, at length, only a simple crown falls away and a new one has taken its place.

The jaws, therefore, during childhood, especially in its early part, are full of these remarkable organs in active process of growth, and crowded together in such apparent confusion that the wonder is that accidents to their development do not oftener occur—that the teeth are as regular as they are.

The literature of dentigerous cysts is meagre and unsatisfactory. Many of the older writers have failed to mention them

extend beyond the "follicular" stage of Goodsir, dentine only, and no enamel, is found upon the pulp.—Owen, Odontography, p. 17.

* "Odontoblasts," Waldeyer. "Dentinal layers," Owen.

† Although it would be inferred from the older writers, and especially from every picture which I have seen, that the enamel membrane is not connected with the dental germ, yet it seems to me to be its own true epithelium, and that its free surface, properly speaking, is that which faces the enamel pulp; also that this latter is the only "cavity" in the dental sac. The interspace always figured between this membrane and the dentine is probably diagrammatic. If this be so, we have here the anomalous condition of a superficial membrane cut off from supplies below (by the hardening of the underlying dentine) and nourished from its homologically free surface, that facing the enamel pulp.

‡ "Stratum intermedium."

§ This is the view expressed by most authors; but Waldeyer says the office of the enamel pulp is only "transitory and mechanical"; to fill the cavity reserved for the tooth.—Stricker, op. cit. p. 485.

The "membrana præformativa," whose function, and even presence or absence, were for a time the cause of so much discussion and difference of opinion as even nearly to deprive their enamel cells of their traditional office, is, I think, best explained by Waldeyer as *the "youngest softish layer of the enamel," and not a separate membrane.*—Stricker, vol. i. p. 487.

* "Either because it is to become useful as a 'gubernaculum,' and its bony canal as an 'iter dentis,' or more probably in virtue of the general law that parts or organs which once acted an important part, however atrophied they may afterwards become, never wholly disappear, while they do not interfere with other parts or functions."—Goodsir, Edin. Med. Jour., 1838, p. 28.

† But where they are unable to do so, the posterior may cause absorption and loosening of the anterior, as if it were merely its temporary predecessor.

at all, while the rest have hopelessly mixed their cases in a confused mass of "spina ventosa" and "osteo-sarcoma." Dupuytren mentions one undoubted case,* and several others which may have been such, but no reference is made to teeth in connection with them, except that one "was caused by the incomplete extraction of a canine."—P. 136. His directions for treatment, however, are excellent; better, in fact, than those of some more recent authors, many of whom have added nothing to his account.

Stanley quotes two cases,† besides others similar to those of Dupuytren; he follows him in pathology and treatment, but recognizes more clearly than he the distinction between cysts in the jaws and the various fluid cavities of other bones, yet fails to see the difference between the true dentigerous cyst and the one "caused by the irritation of a carious or misplaced tooth, and commencing near the extremity of the fang."—P. 300.

Warren gives some interesting cases (none, however, proved to be dentigerous), which he treated admirably and successfully, part of which he considered to be due to trouble at the roots of certain teeth.‡ March relates cases similar to Warren's.§ Jourdain (as quoted by Salter)‖ had three genuine cases. Other observers have each reported an instance, as may be seen in the Appendix. Salter, in Holmes's Surgery,¶ has given the best account of the disease which the writer has seen, and has collected quite a number of cases for illustration, besides giving two from his own practice. More recently, Heath,** in his work on the Jaws, devotes several pages to it, and gives three or four excellent drawings of specimens, but adds nothing new in theory or treatment.

The accounts in the common text-books are only compilations, and all inferior to those of the authors named. Glaswald is said to have written a very fine thesis upon it. It is not a little surprising so many errors should have occurred in the well written article†† of Salter, in which he describes two additional cases.

Clinical History.‡‡—This is, perhaps, the most neglected part in the recorded cases; many entirely fail to give the history of the case. Where it is given, it seems to be simple and easily told: a slow, nearly painless swelling of a portion of the jaw appears and increases, and a certain irregularity (to be referred to again) is noticed in dentition. What distress there is—usually slight, often none—is due to the tension and mechanical inconvenience of the new growth. In most cases this is all. The growth may be uniform and steady, or its progress may be retarded and again make fresh advances. It never diminishes. It may open in the mouth or through the cheek, causing either a permanent fistula, or it may close and open alternately. The wall of the antrum is usually compressed, rather than broken through; but this accident undoubtedly happens, and it often is impossible at the time of operation to say whether the cavity opened is the antrum or separate from it. Inflammation and suppuration often occur, but are not peculiar to dentigerous cysts. Such cases are apt to be painful. The size of the cavity varies from that of an orange, down.

The liability to cancerous degeneration is not so much feared now as formerly,* but that a fibrous growth occasionally follows has been observed in certain cases of cysts; it is doubtful, however, if such cases were actually dentigerous cysts.†

Case No. 29, which occurred at the Boston City Hospital, in Dr. Thorndike's service, while the writer was his assistant, may be read as a typical example of the simple form of the disease. This, with Nos. 27 and 28, which occurred in his private practice, and No. 26, from that of Dr. Cheever, have not been published before, and are now presented with the permission of these gentlemen.

There are certain cases accompanied by a considerable amount of pain, either from the very first, or coming on after a little,

* That of M. Loir. "Leçons Orale de Clinique Chirurgicale," Paris, 1839, t. ii. p. 135. Also Appendix, No. 22.

† Diseases of the Bones. Also Appendix, Nos. 9 and 10.

‡ Surgical Observations.

§ New York Medical Soc. Trans., 1856, pp. 163 & 164.

‖ Holmes's Surgery, vol. iv. ¶ Ibid.

** Heath on Injuries and Diseases of the Jaws.

†† Guy's Hosp. Rep., 3d Ser., vol. xv., 1870.

‡‡ While the opinions of authors have been freely used in the following paragraphs, more weight has been given to the teachings of the cases themselves. On this account some of the following statements will be found different from the usual accounts, but a reference to the table will sustain them.

* "Le marche des kystes ossieux est généralement lente. Au bout d'un temps plus ou moins long ils passent a le dégénérescence cancereuse, surtout ceux dont les produits sont fibro-celluleux."—Dupuytren, Leçons, &c., t. ii. p. 140.

† The prognosis, says Mr. Syme, is more favorable if a tooth be found in the cyst; it is then almost certain that it will contract and heal. This may occur in other cases, but it has been noticed that cysts, after being opened, are not unfrequently followed by the formation of a solid tumor. I could mention to you cases where I have opened cysts *containing nothing but serum*, in the place of which solid tumors have afterwards been formed.—Lancet, March 10th, 1855, p. 253.

and lasting until interfered with. These either arise from a blow or injury, in cases where the errant tooth is pushing away obstructions to its progress, or such as are accompanied by some less usual complication.

The diagnosis requires, first, the recognition of a hollow growth, and, secondly, the knowledge that it contains a tooth. The first is accomplished by physical examination, and would seem easy enough; yet a large proportion of the cases of removal of the bones for this disease were done through a mistake on this very point. The history of the case is not essential to this examination; yet an account of much pain, or cancerous tendency, would, of course, receive attention. An irregularity of its surface, polypi of the nose or pharynx, or a fungous appearance, are indicative of a solid tumor. A painless swelling of either jaw, of not very rapid growth, should always suggest the possibility of a cyst, and lead to a careful examination of every part of its surface, both over *the cheek and within the mouth.** Fluctuation will usually be detected in certain places at least, although the greater portion may be bony and unyielding.† If these thinner spots be indented, perhaps they will return to their places with a crumpling sound which is pathognomonic of a cystic growth; if any doubt remain, an exploratory puncture, which is perfectly harmless, should always be made, as Dupuytren has well insisted:—"Je regarde une crepitation legéré comme un symptome pathognomonique; ce signe merite beaucoup d'attention. S'il y a quelque doute on fait un ponction exploratrice; cette ponction et la crepitation, sont deux symptômes qui ne laissent aucun doute sur l'existence des kystes de cette nature."

The elimination of fluid accumulations in the antrum, old alveolar abscess or cysts containing blood, serum, or other matter, but not teeth, is more difficult. A decision from the above evidence alone would be impossible. There is one diagnostic mark, however, for these cases, which is of the highest value when it can be proved: this is *the absence of a permanent tooth* (which has never been removed) *some time after its appearance is due, in the neighborhood of the cyst, and whose place is quite likely to be filled by its temporary predecessor.* This condition in the mouth, in connection with the swelling, would be an almost positive indication of its nature. While, on the other hand, if all the teeth are present and normal, it is one of the other diseases.*

The predisposing and the exciting causes of this affection should be separately studied. The presence of a tooth in the jaw which has never erupted is, in fact, the only one cause of the disease, since youth and other conditions which have been considered as such are only accidental. The teeth concerned are of the permanent set† and usually delayed in the jaw, either in consequence of the irregular or non-development of their fangs, their deep situation, or wrong direction, or else of the obstinate persistence of the temporary teeth in advance of them.

The exciting causes are often unknown and probably various. The attempts of the impacted teeth to reach the surface have an exciting action in certain cases; but on the other hand such teeth may lie quiet in the jaw during the entire life, and cause no trouble, or may be found enclosed in a cyst after all attempts at growth had been given up for years. That the disease should follow the extraction or aching of carious teeth, is not remarkable, considering how common these are at all ages; yet such irritation in some cases may have been the exciting cause as well as the obstinate resistance of a milk tooth to the advance of its follower. In the first and second cases given in the tables the disease was evidently excited by the blows which preceded. The additional presence of undeveloped teeth in the jaw is, of course, essential in all these cases, for without these the affection *cannot exist.*

(To be concluded.)

* "They are generally at some parts as hard and as unyielding as the bone, so that if the examination be limited to these the mass will be supposed to be solid."—Syme, op. cit., p. 253.

† Judging from the *non-ossification of the old "gubernaculum"* and the cases which I have seen, I shall venture to say that that portion of the wall under the gum where the *missing tooth should normally have appeared* will always be found *membranous or else very thin.*

* Rare exceptions may occur to both these statements. Teeth may be indefinitely impacted or undeveloped, and yet produce no disturbance, or may be absent altogether—the missing member never having had an existence—or they may be the innocent participants of an independent growth, as where they become involved in solid tumors. A supernumerary and a temporary tooth have each been found at fault. (Appendix, Nos. 16 and 20.)

† One exception, No. 16.

A CASE IN PRIVATE PRACTICE.

By E. P. Hurd, M.D., Newburyport.

I was called to attend J. B., of this city, aged 23, married, on Sunday evening, Aug. 6th. His symptoms were those of bilious colic—severe griping pains in the bowels

and vomiting. He had come home from a ride in the afternoon, and had partaken freely of milk and green apple-pie. Diagnosis—irritation of bowels from undigested material. When the vomiting had been sufficiently quelled by small doses of submuriate and opium, I gave a purge of five grains of calomel, half a drop of croton oil and one fourth of a grain of opium. This operated freely at 2 o'clock, A.M., and gave so much relief that the patient slept.

Monday morning, Aug. 7th.—The pain appeared much relieved, but was occasionally troublesome. Some tenderness in right iliac fossa; tympanites and fever; puise full and hard, about 80; head hot, and expression listless; tongue moist, with light creamy fur; stomach no longer irritable.

℞. Tinct. aconite, gtt. xx.;
Fluid ext. ipecac., ʒij.;
Tinct. opii, ʒiij.;
Aquæ ad ʒiv.

S. A teaspoonful every two hours, to be taken with the ordinary effervescing fever mixture. Turpentine stupes to abdomen. Corn coffee for nourishment.

Tuesday.—Mr. B. had a tolerably comfortable day yesterday, having but little fever, perspiring a good deal, and suffering but little pain. The tinct. opii in the medicine kept pain in check. Diarrhœa, with thin, feculent evacuations. Tongue moist, pulse good. He had a chill at 4 o'clock, A.M. Quite high fever followed the chill. Diarrhœa appeared to give relief to pain and flatulence. In the afternoon the diarrhœa stopped, and, the tympanites and pain being aggravated, an enema of warm water brought a copious watery discharge, with expulsion of flatus. The discharges from bowels have been watery, but never mucoid. A powder of calomel two grains, and opium half a grain, was rejected by vomiting. Ipecac, aconite and laudanum mixture to be continued. Tympanites, tenderness and gurgling in right iliac fossa are well marked.

Wednesday.—Patient had enjoyed a good night's sleep. All the symptoms appeared better. Occasional attacks of pain, but the laudanum in the mixture relieved. Ordered half a teacupful of beef-tea every three hours for nourishment. Diarrhœa running on, but not profuse; stools resembled the dark, liquid dejections of typhoid fever. Gurgling in iliac region, but no petechiæ. Dulness and hebetude very marked. Would doze most of the time.

Thursday.—Matters seemed to be progressing favorably. Fever of a mild type. Pulse regular and good. The pain occasionally severe, and was only relieved by stupes and laudanum. Prescribed elixir vitriol with laudanum. Dulness continues; he appears to sleep, but is easily aroused.

Friday.—Augmenting tympanites. Pain more severe. More laudanum had been required. Bowels not moved during the night, and an enema was deemed necessary. This brought back the diarrhœa, and gave some relief. Thin arrow-root gruel was permitted; of this, however, he drank little. Cold water continually craved. Fever mild. No marked exhaustion. He insisted on getting out of bed to attend to the wants of nature. The ordinary debility of typhoid fever was wanting.

Saturday.—Fever more steady, and constantly increased tympanites and pain. Saturday night he got no sleep, though the laudanum was given in larger doses. Diarrhœa persistent.

On Sunday, leeches were applied over the tender region, followed by fomentations and poultices. This brought relief from the excessive pain. Sunday night, the pain returned with greater severity, and was only mitigated by the constant application of hot poultices. Little or no sleep. Tongue dry and smooth. Tympanites considerable. Ordered five drops oil of turpentine, in emulsion, with ten drops of laudanum, every two hours, thinking that the alterative action of the oil might be beneficial. I dreaded perforation of the bowel, and, acting on Dr. Wood's suggestions, thought the turpentine indicated.

Monday morning, Mr. B. appeared as well as the day before. Occasionally hot and feverish, and occasionally cool and perspiring, with soft and regular pulse. Tongue still dry. No complaint of the turpentine, which has been continued. Poultices appeared to give ease.

Noon.—Increase of tympanites and pain. Introduced into the rectum the enema tube, which helped expel much flatus. Dejecta very offensive, of dark, watery substance. Pulse natural.

Afternoon.—Pain increasing. Injected, hypodermically, one fourth of a grain of morphia. Carminatives (mint and anise) gave some relief by promoting expulsion of flatus both ways.

7 o'clock, P.M.—Mr. B. had slept one hour, and was more comfortable. Had had one discharge of dark offensive liquid from bowels, and passed water at 5 o'clock. Pulse 80. Considerable febrile heat, and dry tongue.

8 o'clock.—Was sent for in great haste. "Something had given way"; that was

the sensation, as he expressed it. Agitation, restlessness, vomiting of dark-green, bilious liquid. Pain and burning in stomach. I thought of strangury, and introduced a catheter and drew off a little urine, but without relief. I believed there had been perforation of the bowel by an ulcer, and escape of fluid into the peritoneal cavity. Drs. Cross and Snow were called in consultation.

Treatment.—Two grains of opium every hour till relief. Several doses were administered before pain and vomiting ceased.

Symptoms of collapse speedily set in. Pulse in one hour ran up from 96 to 160, and became small and thready. Body bathed in cold clammy perspiration. The usual supporting treatment was of no avail. At midnight he was nearly pulseless, yet his mind remained clear. Abdomen enormously distended, and now very hard. Percussion gave a dull sound. Fluctuation could be detected. The peritoneal cavity was evidently full of extravasated fluid and inflammatory serum.

At 11, A.M., he sank and died.

Was this a case of typhoid fever, attended, on the eighth day, with perforation of the bowel, and rapidly ensuing death from peritonitis? If so, it is an unusual case. Or was it more properly a case of enteritis, with perforating ulcer?

Could any other treatment have been more successful?

It is to be regretted that a *post-mortem* examination could not be obtained.

Selected Papers.

CONIC ACCOMMODATION IN THE COMPOUND EYE.

By Russell Murdoch, M.D.

Dr. Russell Murdoch, at the last meeting of the Baltimore Pathological Society, showed how cones in the compound eyes of insects are adapted, *by reason of their shape*, to produce distinct images on the retina of objects *at all distances*, and that the single function ascribed to them—"of cutting off lateral rays, and admitting to the retina only such rays as directly face them"—is but a part of what they accomplish. He recalled the anatomical structure of these eyes—that they possess no crystalline lenses, and that the cornea, in different species, vary from concavo-convex, plano-convex to bi-convex. The irides are frequently absent or rudimentary; but if present, are fixed, and therefore do not take any part in regulating the different amounts of illumination for varying distances. These irides are situated between the layers of the cornea, thus foreshadowing the future separation of cornea and lens. It was shown, therefore, that there was no provision for focal adjustment, such as is found in the higher type of eye; and *à priori*, he argued, any such adjustment, depending on the comparatively slow muscular action to accomplish it, would be totally inequate for the rapid flight of insects—as, for example, where the dragon-fly is pursued by the swallow, in the well-known experiment so often quoted.

He showed how parallel rays from distant objects are focused on the retina, and how the sides of the cones, being radii of the corneal sphere, surround and take the direction of these cones of rays. It is not so with rays from near objects, for these are divergent, and after passing through the cornea separate—or are too large for the cone, and, therefore, the most external ones, as the object approaches, are, one after another, lost on its pigmented sides. The central straight rays, limited in number by the amount of truncation of the cone, form a distinct image at whatever peint they meet the recipient surface.

It might at first sight be objected to this hypothesis, that so few rays would interfere with adequate illumination; but the deficiency of rays is compensated by the greater illumination of each ray proceeding from a near object.

The fixation of the pupil and the absence of the ciliary muscle, are both introduced for the same end, viz.: to dispense with the appreciable interval required for muscular contraction. The great Mechanist, although apparently committing an oversight, has improved in rapid adjustment on the method best known to us, and the one we have adopted in all of our optical instruments.

He showed further that the isolating function, usually ascribed to these cones, is another mechanical contrivance for dispensing with the still slower action of rotation which is found in the spherical eyeball. The isolation of cones, coupled with the prominent position of the compound eyes, allows of an unlimited field of vision, as well as an unlimited and simultaneous accommodation in different cones—one set of cones might be directed to, and would

focus a pursuing enemy at a distance, while another would accurately define a near object.

This very great perfection of vision, it will be remembered, takes place on both sides of the body, thus further dispensing with the still slower process of rotating the head.

The objection to the fusion of so many separate images and their proper interpretation by the brain, presents no greater difficulty than the union of the two distinct images of the two organs into one impression, as occurs in those animals having an antero-posterior direction of the optic axes.

Dr. Murdoch proposed the name of conic or passive accommodation, to distinguish this from active or muscular accommodation of the globular eye.—*Baltimore Med. Journal.*

DISEASE OF THE ANTRUM.

By C. S. Chittenden, L.D.S.

On the 30th of August, 1870, a stout, sturdy Englishman called on me to have the roots of the left superior second bicuspid extracted. The face was most fearfully swollen, the swelling commencing about the orbital edge of the malar bone and extending downward to a point a little below the alæ of the nose, and puffing out in the centre, much as if the half of an egg, cut longitudinally, had been placed under the skin. The surface was very hard and intensely red, the appearance being unlike anything I had ever seen before. I made a good many inquiries, from which I gathered that the swelling first commenced about seven years before, and had given more or less trouble ever since, but had never been as painful or as badly swollen as when he came to me. I also learned that on three or four occasions he had consulted physicians, who had opened the enlargement in the cheek, from which, so far as he knew, there had been no discharge but blood.

The gums were perfectly healthy, there being no inflammation about the roots of the bicuspid even. Suspecting disease of the antrum, I plied him with the usual questions, but failed to elicit anything from him that would lead me to decide positively as to whether the cavity were affected or not, and as I could see no other cause for the trouble, I decided to make an opening into it. For this purpose I extracted the roots, which were removed without difficulty, and then attempted to pass a small drill through the socket of the palatal root, but as it caused him a good deal of pain I desisted for a moment, and then inserted the drill into the socket of the buccal root and gave it two or three turns, when I found it had passed entirely through the bone. I withdrew the drill, expecting to see it followed by a discharge from the swelling; but, as nothing came away, I took up a small probe and passed it through the opening made by the drill, and pressed it up till he asked me to stop, when I found, on measuring, that it had passed up an inch and a half from the edge of the gums. Still there was no discharge. I then took a fine excavator, the shaft of which was bent at an angle of forty-five degrees, and passed that up nearly as far as I had the probe, and rotated it sufficiently to break up any saccular formations within its reach, when fully half a teacupful of very offensive matter was discharged. When all had passed out that would do so, I injected tepid water into the cavity several times till it seemed pretty well cleansed, when I threw in a mixture of iodine and carbolic acid, and placed a tent, saturated in the same mixture, into the opening, and requested him to call the next day.

August 31st.—Patient called according to appointment. Found the cheek distended nearly as badly as at first. On removing the tent, nearly as much matter was discharged as on the day before.

I filled the cavity with the same mixture, placed another tent in the opening, and requested him to call the next day, which he did. I continued to treat in the same manner for some time, with very little improvement. On probing the cavity carefully, I found that the external wall of the antrum was almost entirely eaten away, so that he could, by sucking, draw the cheek into it, leaving quite a depression on the outside.

On the 8th of September I resolved to try nitric acid, very much diluted, as an injection. Accordingly, I put three or four drops of the acid into a tumbler of water, which diluted it so much that there was only a slight sour taste to it, and injected a syringeful into the cavity every day for a week. From that time he improved rapidly, and in two weeks I discharged him, cured. The opening into the nose was evidently closed, and he positively refused to allow one to be made there. So I could only do the next best thing—form an artificial one into the mouth, which I did.—*Canada Journal of Dental Surgery.*

TWO CASES OF SYPHILIS PRESENTING INTERESTING FEATURES.

By R. W. Taylor, M.D., Surgeon to the New York Dispensary—Department of Venereal and Skin Diseases.

The two following cases of syphilis present interesting features, in the fact that their period of incubation was much shorter than is ordinarily observed :—

M. M., a Pole, aged 32, came to the New York Dispensary, January 17th, 1870, and presented a very peculiar lesion upon the penis, about which he was much concerned. Upon the inner aspect of the right lip of the meatus urinarius was a spot about the size of the heads of two pins, which presented a silvery appearance. It was not at all elevated, but directly continuous, without any elevation or fissure, with the surrounding membrane, and there was no fissure, however slight, through the spot itself, as I examined it with the aid of a magnifying glass. I thought that perhaps the man had cauterized it with nitrate of silver, but he said he had not interfered at all with it. He further stated that he had had connection with a woman the day before, and that he noticed this spot that morning. It was evident that the lesion consisted in some change produced upon the superficial epithelial cells of the part. Prof. Boeck, of Christiana, who was present with me at the examination, and observed the case carefully, remarked that he had seen the initial lesion of syphilis once or twice before begin in this manner upon the penis, and that he had often observed it commence in this manner in the mouths of children; this latter fact I have verified clinically since my attention was thus called to it. I suggested to Dr. Boeck that the incubation was very short, but he said that this happened exceptionally. I then questioned the man very minutely, and he persisted in his statement that he had not had any connection except the one for months, and that then he had cohabited with his wife, whom he had at that time left in Europe. In the two succeeding days the area of the silvery patch increased very little, and in four days a small amount of induration could be distinctly felt, as the parts were so accessible to careful manipulation. In a week a distinct indurated nodule was formed, which very much everted the lip of the meatus. The inguinal ganglia had by this time become perceptibly enlarged. When the nodule, which, though no larger than a small pea, but which was very firm in consistence, had existed about a week, the epithelial scales which covered it were cast off, and then a very slightly grayish ulcerated surface was observed, the granulations of which were very small, and it was covered with a very scant viscid secretion. At Dr. Boeck's suggestion, I inoculated some of this secretion upon the hypogastrium of the patient, and when the scarifications had healed, at the end of about three days, a very minute, pale-red papule appeared, which at the end of a week had a diameter of about one third of an inch, and an elevation of about one third of a line. Dr. Boeck informed me that he had observed the same thing quite often when inoculating with the secretion of an unirritated hard chancre. This papule remained without any other change than a slight desquamation, for about a month. The indurated sore remained in a sluggish condition for about six weeks, when a roseola, erythema of fauces, and general *malaise* supervened, which were all treated by mercury, and disappeared quite rapidly. I have seen him this year again, and treated him for a relapse, and at the same time saw his wife, and ascertained that she had not had syphilis prior to her arrival in this country.

The chief point of interest in this case is the remarkably short time in which the initial lesion of syphilis was developed. And, as there could certainly be no motive on the part of the patient to deceive me by saying that he had had but the one suspicious connection, we may reasonably accept it as a case quite unique in itself. I am fully aware of the many difficulties and sources of error to be encountered in clinical observation, and I endeavored, as far as possible, to eliminate any fallacies. But the interest of the case is not alone confined to its short incubation, but it is also very interesting in its course. We seldom have the opportunity of inspection of a hard chancre from its first evolution to its maturity and involution, but in this case all the features attendant upon these stages were accurately traced. Again, another point of clinical interest is the development of a papule by auto-inoculation of its secretion.

F. G., German, 21 years of age, came to me on the 19th of February, 1871, and presented a fissure extending in the median line from the preputial orifice up to the point of insertion of the frænum into the glans penis. It had an irregular, slightly ulcerated surface, and palpable induration was observed in its whole extent. The inguinal ganglia were slightly enlarged, one

on the left side being rather larger than the rest. He said that exactly one week before he had had his only connection with a woman, and that in the act he had torn his prepuce, which was naturally long and tight. I ordered him to dress the ulcer with a very mild solution of carbolic acid; but it gradually became more indurated, until it produced complete phymosis, and then I advised him to inject the same lotion between the parts. It ran a sluggish course, the inguinal ganglia became larger and harder, and he had a roseola in five weeks, which would be exactly six weeks from the day of connection.—*Amer. Jour. of Syphilography and Dermatology.*

Bibliographical Notices.

On some Disorders of the Nervous System in Childhood: being the Lumleian Lectures delivered at the Royal College of Physicians of London, in March, 1871, by Charles West, M.D., Physician to the Hospital for Sick Children, &c. Philadelphia: Henry C. Lea. 1871. Pp. 131.

The Lumleian Lectures, which, since the year 1572, the date of their foundation, have been delivered by the most eminent professional men in England, at no time have had a more able exponent and one more heartily respected than Dr. West. To him the profession are indebted for several very excellent text-books on the diseases of children; and largely to him is due the foundation of the Hospital for Sick Children, in whose wards much of practical value in the treatment of children's diseases has been learned.

"My life has been passed very much among the young," says Dr. West. "I have lived with children; their ways, their wants, their sufferings are more familiar to me than those of grown-up people; and I prefer, therefore, to take some of their ailments as the subject of these lectures."

With this as his text, and in the pleasant style which makes Dr. W.'s works always attractive, he places before us some excellent thoughts on Neuralgia and Epilepsy, Chorea and Paralysis, Disorder and Loss of Speech, and Mental and Moral Peculiarities and their Disorders. It is an excellent little manual, and a worthy companion to the other works for which we are indebted to Dr. West.

A Manual of Midwifery, including the Signs and Symptoms of Pregnancy, Obstetric Operations, Diseases of the Puerperal State, &c. By Alfred Meadows, M.D., M.R.C.P., Physician to the Hospital for Women, &c. First American Edition. Philadelphia: Lindsay and Blakiston. 1871. Pp. 487.

This work bears evidences of worth, being a thoroughly practical, well-written and safe guide, both to the student in forming his estimate of his future duties and to the practitioner in the study of his cases.

This edition, the second English, has been carefully revised throughout, and much new matter has been added. It has not escaped the limits which make it a text-book of *moderate* size, yet it is sufficiently full in its descriptions to make it useful where knowledge is actually needed. It has been sent us from the "old-corner bookstore" of Messrs. A. Williams & Co., 135 Washington Street.

A Practical Treatise on the Diseases of Infancy and Childhood. By T. H. Tanner, M.D., F.L.S., &c. Third American Edition, from the last London Edition. Revised and Enlarged, by Alfred Meadows, M.D. Lond., M.R.C.P.L., &c. Philadelphia: Lindsay and Blakiston. 1871. Pp. 559.

The work of Dr. Tanner, which is already so familiar to us, has been re-arranged, and much has been added which enhances the value of a book already highly prized by the profession. The recent death of the author makes its appearance at this time none the less attractive.

This volume, like the others for which we are indebted to Dr. Tanner, bears marks of that essentially *practical* character which makes it valuable to the busy physician. It is sufficiently full for information, it is modern in its idea, and sound in its treatment.

The Physician's Prescription Book: containing Lists of the Terms, Phrases, Contractions and Abbreviations used in Prescriptions, &c. By Jonathan Pereira, M.D., F.R.S. Fifteenth Edition. Philadelphia: Lindsay and Blakiston. 1871. Pp. 286.

This little Prescription Book is well known to the profession, and worthily so. The present edition contains a large number of additions and alterations, necessitated by changes in the British Pharmacopœia.

The Principles and Practice of Dentistry, including Anatomy, Physiology, Pathology, Therapeutics, Dental Surgery and Mechanism. By CHAPIN A. HARRIS, M.D., D.D.S., &c. Tenth Edition. Revised and Edited by PHILIP H. AUSTEN, M.D. With 409 Illustrations. Philadelphia: Lindsay & Blakiston. 1871. Pp. 794.

THE publishers of the new edition of Harris's Dentistry have truly merited the esteem of the profession. The work, which has always been looked on as a compendium of all that is valuable in dental science, has been so thoroughly revised and modified that it is in fact a new work—indeed, the advances in dental physiology, pathology and surgery have been so great that a re-writing of articles on some of the subjects has been demanded in order to bring the book up to the standard which the science demands. Prof. Austen, the friend and former associate of Dr. Harris, has well performed his task of re-editing, and has been ably seconded by Drs. Gorgas and Latimer.

We have looked carefully over the sections devoted to Anatomy and Physiology, Pathology and Therapeutics; they are carefully written, and give as clear a view of the subjects in question as possible in a general text-book. Except the chapters on Odontalgia, Extraction and Anæsthetics, Fracture and Dislocation of the Maxilla, and Diseases of the Antrum, the remainder of the book, namely, that devoted to Dental Surgery and Mechanics, is to us a *terra incognita*. We find ourselves lost among pluggers and scalers, plates, porcelain teeth and moulds, all of which articles, however, we are led to believe the author describes in a manner at once valuable and intelligible.

We cannot suffer to pass without notice a singular paragraph on the use of anæsthetics in the extraction of teeth; a passage, indeed, which abounds with such palpable crudities that no other mention need be made of it than to reproduce it.

"The practicability of producing anæsthesia with ether was first demonstrated by Dr. Horace Wells, of Hartford, Conn., in 1846, and soon brought prominently before the medical and dental professions by Dr. W. T. G. Morton, of Boston, Mass., both practical dentists; and with chloroform, in 1847, by Prof. J. Y. Simpson, of Edinburgh, Scotland. The anæsthetic effect is obtained by inhalation of the vapor, and is supposed to be nothing more than a transient state of intoxication, which usually disappears almost immediately after the discontinuance of the administration, though in many cases it has proved fatal. * * * The first (ether), however, is less dangerous than the second (chloroform); but its anæsthetic effect is less certain and prompt, from seven to ten minutes being usually required, whereas, with the other, it is obtained in from thirty seconds to two minutes. When ether is used, from six to ten or fifteen ounces are employed," &c.

Medical and Surgical Journal.

BOSTON: THURSDAY, SEPTEMEBR 7, 1871.

TERRORISM OF THE PRESS.

WE have often felt disposed to complain of the tendency apparent in the non-medical press to enter the field of our profession and, by the publication *in extenso* of such matters as professional quarrels, discussions on scientific subjects, on the treatment of disease, the rise and progress of epidemics, and the use of remedies, to foster a public interest in topics which are strictly technical. Such subjects as these have their place in professional journals, where they can be seen and considered by medical and scientific men.

We would not interfere with popular rights, we would not restrain the spread of public intelligence, or object to such public interest in matters of the profession as shall secure righteous and wise legislation; but we do *protest* against the practice of editors, admirably versed without doubt in the duties of their legitimate province, of writing apparently learned disquisitions on subjects for which their unfitness is shown by the crudities which are painfully apparent to every medical man.

We would, however, at this time, speak more particularly of the system of *terrorism* adopted by the secular press, of late, in reference to the spread of epidemics, and to matters of hygienic interest. We have before us extracts from recent newspapers which proclaim it as an undoubted fact that the Asiatic cholera is coming to our shores—that our cities are in very poor condition for its reception—and that its advent will cause great destruction of life. We

hear predictions of the decimation of our population; while in some countries of Europe it is announced that "disease will riot over the fields war has blasted, and death will reap another harvest not less awful because less bloody." This may be very well for a sensational article, but is it likely to be true? and, if so, is it well for the public journals to excite the community beforehand on the subject? English secular journals have recently discussed, in a thorough manner, the smallpox question, debating in learned terms, but with more or less of error, the intricate questions which medical men even cannot determine, and have succeeded in bejuggling the public mind beyond hope of restoration. Even one of our respected foreign exchanges makes the suggestion that persons should avoid riding in cabs, and should be careful about hiring apartments, for fear of smallpox.

We assert not only that the discussion of such subjects is beyond the province of non-professional journals, and that more error than truth is likely to be taught by such discussion, but that the excitement of the public mind induced thereby is a consideration which should have serious weight, simply adding, as it does, fuel to the flame which it is desirable to quench.

Middlesex East District Medical Society. — At the annual meeting of this Society held at the house of Dr. J. C. Harris, in Arlington, May 10th, the following preamble and resolutions were passed by the Society:—

Whereas, The medical profession is not a trade, in the common acceptation of that term, and whatever tends to reduce it to that level is derogatory to its true dignity and antagonistic to the usefulness of its members, therefore

Resolved, That the publication of petty accidents in local newspapers accompanied by the name of the medical attendant, at his instigation or by his connivance, is an infringement of both the letter and the spirit of the Code of Ethics.

Resolved, That it is the duty of the members of this District, whose names may appear in such paragraphs, to take all necessary steps to prevent the same occurrence in future, by notifying local publishers of newspapers not to insert their names in notices of accidents.

Resolved, That the above resolutions apply to all publications of medical matters in secular journals accompanied by the name of the physician interested, when such publication is made at the instigation or by connivance of a member of this Society.

Voted, To send copies of these resolutions to the Boston Medical and Surgical Journal and to the secular journals of this District for publication. A. H. Cowdrey,

Secretary Middlesex East. Dist. Med. Soc.

On the Reproduction of the Epithelium of the Cornea.—In some experiments in this direction, by Dr. Hjalmar Heiberg, of Christiania (*The Academy*, April 15, from *Stricker's Medizinische Jarhbücher*, 1871, Heft 1), the epithelium was scraped off clean with a scalpel from a small space on the surface of the cornea, and a series of corneæ so prepared was studied after intervals of five, six, eighteen, &c., hours. Immediately after the operation the free space is bounded by sharp vertical edges, which in five or six hours become flattened, so that the boundary line is no longer well defined; in eighteen hours the space is reduced one-half, and in from forty hours to three days it is entirely covered over. Microscopically it was found that the epithelium was reproduced only around the edges, so that an insulated spot of epithelium never appeared. In the reproduction of common skin over abraded surfaces, Dr. H. believes that the parent epithelium of the spot is derived from some destroyed gland-duct, and, as there are no glands in the cornea, the phenomenon cannot occur here. Some of the corneæ were watched for from two to five hours. Wander-cells were observed on the free surface of the corneæ, in its substance, and also among the epithelial cells, but Dr. H. was unable to observe the transmutation of these cells into epithelial cells. Between the mass of old cells and the two or three rows of new ones was seen a zone of yellowish masses, apparently of intercellular albuminous substance, which appeared to have always a centre of aggregation. They executed amœboid movements, and one of them was observed to separate into five rounded masses. Dr. Heiberg's conclusions were, however, drawn from the investigation of sections of the cornea treated with perchloride of gold. Apparently, two layers of cells advance over the denuded space, the cells of the outer layer sometimes advancing over those of the under, and sometimes *vice versa*.

Cells with many nuclei rarely occur, but

one was observed containing five. Dr. Heiberg believes that the cells around the edge of the bare space send out processes in which there appears a translucent spot, which spot becomes the nucleus of the cell thus formed. He thus thinks that the nuclei of the new cells are not derived from the division of those of the parent cells. These become the parents of others in the same manner, and thus the space is partially filled up. These results are opposed to those of J. Arnold, who says the new cells are developed out of a finely granular mass, which first coats over the abraded surface. —*Phil. Medical Times.*

Mr. W. Adams *(British Medical Journal,* May, 1871, p. 525) has arrived at the following conclusions respecting the conditions of the coxo-femoral articulation in anchylosis. The conclusions are adduced in support of the author's proposed operation for subcutaneous division of the neck of the thigh-bone :—

1. In rheumatic anchylosis no destruction of bone ever exists, and the head and neck of the thigh-bone, therefore, always remain of their natural size.

2. In anchylosis after pyæmic inflammation, more especially in its subacute form, from which the patient frequently recovers, destruction of bone rarely if ever exists, the soft structures only being destroyed.

3. In anchylosis after traumatic inflammation in healthy adults, such as that which occurs after wounds of the joints, and gunshot wounds in the neighborhood of the joints, the joint itself having escaped injury, and in some cases of anchylosis chiefly from long-retained position, as a general rule, no destruction of bone occurs, even after acute suppurative inflammation, the soft tissues only being involved.

4. In anchylosis after strumous disease of the joint, when arrested in the early stage, without the occurrence of suppuration, or, at least, of abscess bursting externally, there is generally only a superficial caries of the head of the bone; and, the destruction being thus limited in extent, the neck of the thigh-bone remains of its natural length, although practically somewhat shortened by being depressed or sunk into the acetabulum.

5. In anchylosis following the more severe forms of strumous disease, in which there have been evidences of caries and necrosis of bone, with abscess bursting exterternally and remaining open a considerable time, generally giving exit to small particles of bone, destruction of the head and neck of the thigh-bone, to a greater or less extent, may be diagnosticated.—*Ibid.*

A Case of Placenta Prævia, with Remarks. By B. G. McCabe, M.D., Monticello, New York.—Placenta prævia being of comparatively rare occurrence and fraught with such alarming consequences, it seems eminently proper that each member of the profession, when opportunity affords, should throw what light he can on its nature and treatment, especially if of a practical character. And it is for this reason alone, rather than to offer any new theory, or to advocate any favorite hypothesis, that this article has been prepared.

Mrs. L. H., aged 33 years, was pregnant with her fifth child. Everything went on well until the commencement of the seventh month of her pregnancy. On the 12th day of June was first called to see her. I found her suffering from quite a severe attack of hæmorrhage (which had been coming on gradually for about a week); the mouth of the womb high up and not dilated sufficiently to admit with ease the point of the index finger. I directed the patient to be placed in a cool room, with light clothing, applications of cold water to the vulva, and enjoined perfect rest, cool drinks, the feet and hips to be elevated, which, in a few hours, checked the hæmorrhage. I informed the family of the nature of the trouble, and requested that I might be called immediately if she was taken worse. In two or three days, on getting up, the hæmorrhage returned again, but there being but slight dilatation of the os uteri ordered the same applications to be made, and in addition the alum plug and tampon, which was continued with intervals of a day or two, till the 21st of June, when she was taken with more active hæmorrhage, and with slight labor pains and some dilatation of the os. Knowing the difficulty with which the mouth of the womb is generally dilated at that early stage of pregnancy, and hoping that labor might come on, I thought it best to watch the patient and wait. Early on the morning of the 22d, the hæmorrhage coming on more violently, the os having dilated to the size of a half dollar, and fearing that the strength of my patient would soon begin to give way from the protracted hæmorrhage, I determined to wait no longer, but to proceed at once to deliver her. Summoning my partner, Dr. E. F. Quinlaw, who put her under the influence of ether, I proceeded as follows:

Placing her in the position for turning, I gradually and slowly dilated the mouth and neck of the uterus with my fingers, bringing it into a conical shape, till able to introduce the whole hand. Passing it along by the side of the placenta, when above it I ruptured the membranes, grasped the feet which I found occupying the right side, and when brought down waited a few moments and gave her one drachm of Squibb's fluid extract of ergot; then delivered the child, which I found alive, although partially asphyxiated. The placenta soon followed, and the uterus contracted down actively and firmly. The mother and child at this time (ten days after the delivery) are both doing well.

A few practical thoughts on the above. I gave ether in this case, not from choice (as I prefer chloroform in obstetrical operations), but for two reasons: 1st. I expected to keep her for some time under the influence of the anæsthetic, as the os and cervix uteri are more thickened and contracted at seven than at nine months, taking a longer time to dilate them. I therefore considered ether the safer of the two. 2d. Because I wished, after turning the child, to rally her from the anæsthetic sufficiently to enable me to give ergot, so as to insure permanent contraction of the uterus, which it did. If given prior to the anæsthetic, unless one is quite expeditious, it will materially interfere with the operation of turning; and the amount of time taken up in bringing the patient under the influence of the anæsthetic, and the trouble and time required in dilating, the most expert cannot always foresee. I apprehend that many fail in dilating the os uteri as early as desirable from their being in too great haste to accomplish it. In this case, no doubt, by taking a longer time, I might have dilated sufficiently to have introduced my hand several hours earlier. From the experience I have had in several of these cases, during the past 25 years, I am of opinion that any physician is justified in not waiting till the os is dilated to the size even "of a half dollar" before he operates, especially if at or near the full time, the hæmorrhage is active, and the os dilatable. It is a nice point, to be sure, and requires the greatest coolness on the part of the accoucheur, to act just at the proper time, but I think it is better to be ready a little too soon than a little too late. I believe there is but little danger from violent hæmorrhage, while dilating the os after the first gush of blood is passed, if the points of the fingers when once inserted are not withdrawn, but gradually and *persistently* carried up till the work is accomplished, as you have as good a plug while doing it as one could desire. Counsel is always desirable, and the timid should by all means avail themselves of it, or pass the patient into other hands.—*New York Medical Record.*

Case of Sudden Death after Labor. By Thomas F. Cock, M.D., New York.—A. W., primipara, æt. 36. Confinement was expected in the latter part of April. She enjoyed good health during her pregnancy, being free from most of the discomforts attending that condition, and was actively engaged in household duties. She was free from œdema, headache, nausea, or dyspnœa.

On the 26th March she had some hæmorrhage, not the result of exertion, and so slight as to have ceased before my arrival. No examination was made.

On the 3d of May I was summoned early in the morning on account of hæmorrhage, which had taken place soon after rising. I saw the vessel containing the blood, and also the clothes; the whole quantity was less than a quart, and no effect on the pulse was noticeable.

Supposing that the placenta was presenting, an examination was now made. The os uteri was undilated, and no evidence of the presentation could be ascertained, only the fœtal head was obscurely felt through a thick cervix uteri. The hæmorrhage was trifling, but it was deemed advisable to insert an alum plug, which was suffered to remain for twenty-four hours. There was no flow after this, except dark-colored serum. I stayed all night, expecting labor to come on; but there was no dilatation of the os uteri when the alum was removed in the morning (May 4th). About twelve o'clock, midnight, under the influence of moderate pains, the os uteri was found in size about half a dollar; no placental edge could be felt, nor was there any hæmorrhage. About 5, A.M. (May 5) the os had fully dilated, and I ruptured the membranes. After rather prolonged, but not very severe expulsive efforts, the fœtus was born still, a little after 7, A.M. The cord was pulseless, and the umbilical vein had a black streak; it did not bear tension, but tore off at the placental attachment when put on stretch. There was no hæmorrhage, but the pulse had risen somewhat in frequency. The patient now asked for brandy, which was given. On making the examination for the placenta, it was found entirely in

utero; and, pursuing it still farther, was found adherent throughout.

I noticed the patient did not complain as much as usual on the introduction of the hand, nor in fact during all the manipulation necessary for detaching the placenta. By persevering, but not prolonged efforts, the placenta was peeled off and withdrawn. The uterus did not act energetically, but *there was no hæmorrhage*. Ergot was now given to insure contraction, and manual compression was continued; but the uterus did not respond to these efforts. The pulse became more frequent and more feeble, and the patient more inanimate, without jactitation. Brandy was given as freely as she could take it, but without response in the pulse.

Fearing there might be internal hæmorrhage, I reintroduced my hand into the uterus, and found about two ounces of clot. A bit of the placenta about an inch square was removed.

The patient continued sinking—the face was not anæmic but rather flushed, and the lips purple; there was no jactitation, no marked dyspnœa—the intelligence was clear. The pulse faded gradually, the extremities became cold, and the patient expired about two and a half hours after delivery.

Neither anæsthetics nor instruments were used during the labor.

Autopsy—Twenty-six hours after death. The body had been kept on ice. The uterus was voluminous in size, its muscular structure apparently normal, its tonicity very feeble. The mucous surface was deeply stained with dark-colored blood; there were no clots in utero, and, with the exception of a small shred of membrane, the secundines had been entirely removed.

The kidneys were large, estimated about eight ounces each.

Liver fatty to a moderate degree.

Lungs exhibited only *post-mortem* congestion.

Heart rather large (about ten ounces), with a very considerable deposit of fat over its surface; but the walls were not so softened, and there was no appearance of interstitial fatty deposit. Valves normal. In the right ventricle was a clot, which extended from the apex through the tricuspid valves, and into the ramifications of the pulmonary artery as far as the second division. Its thickest part was near the apex, where it was lightest in color. Above it became more attenuated in size, but darker in color as far as it was followed.

Remarks.—Painful as is the conclusion of such a case, it is not clear to my mind how the issue could have been averted. The labor was not prolonged nor severe. No anæsthetic was used to impair the action of the heart. The hæmorrhage from beginning to close did not exceed a quart; and previous to labor the pulse was normal. The mode of death was not by anæmia, but more by apnœa.

The heart clot was the only really abnormal result of the autopsy.—*Ibid.*

Dr. M. H. Henry proposes a new method for the treatment of varicocele. In view of the fact that the loss of resiliency in the spermatic veins, resulting in their varicose condition, reacts on the scrotum, producing atony of the dartos muscle and hence a redundancy of tissue, he favors the amputation of a sufficient portion of the scrotum, as a measure promising relief more surely than those hitherto in vogue. In the operation he makes use of a *scrotal forceps*, an instrument having two steel, double-curved and fenestrated blades. The coapting surfaces are notched, so as to hold the tissues more securely, and the double curve is adapted to the natural lines of the the parts. The portion of scrotal tissue to be removed is seized between the blades, and, being held securely by means of a screw in the handles, is excised by means of scissors. Sutures are introduced, and any hæmorrhage controlled before the forceps are removed. The wound requires no extraordinary measures of dressing, and heals readily without complication.—*Amer. Journal of Syphil. and Dermat., July*, 1871.

A Case of Triplets. Reported by Geo. W. Gabriel, M.D., Parsons, Kansas.—The following somewhat singular case occurred in my practice. On the night of March 10, 1871, I was called to attend Mrs. D., who was in labor. She is a woman of small stature, weighs only ninety pounds, and is 47 years of age; is of French descent, though born in Nova Scotia. She had already given birth to eighteen children previous to this pregnancy, and had twins at each of her last three labors. I found her in the first stage of labor, and well advanced, the head presenting in the first position. In about one hour after my arrival she was delivered of a child. On making an examination, I found a second one presenting in the same position as the first. In half an hour this one was born. Soon after, I was surprised to find a third presenting, and in

about twenty minutes she was again safely delivered, making three births in less than one hour. All were males, and fully developed, though small—the three weighing eighteen pounds. The placenta came away promptly, and, though united, I do not think the union was vascular. At the present writing—two months since their birth—mother and children are doing well. She is now the mother of twenty-one children. —*Kansas City Medical Journal.*

Wakefulness.—Dr. Wm. A. Hammond *(Detroit Review of Medicine and Pharmacy)* recommends *phosphorus* for wakefulness. Twelve grains of phosphorus are boiled in an ounce of almond oil and filtered. Half an ounce of this is mixed with an ounce of gum arabic, and fifteen drops of some aromatic oil are added. Of this mixture the dose is fifteen drops—containing one twenty-fourth of a grain of phosphorus. Three doses are given before bedtime, generally producing sleep on the second day if not on the first. The dose may be increased one drop a day until twenty drops are taken, or signs of gastric irritation supervene. He has employed for this purpose the bromide of potassium combined with *sumbul*. The dose of the fluid extract of sumbul (Neergard's) is from twenty drops to a drachm three times a day.—*The Georgia Medical Companion.*

A new Method of Treatment in Epididymitis.—The late Dr. Thomas F. Whitney, of this city, devised the following plan for the reduction of swelling in epididymitis by equable compression, but died before he could communicate it to the profession:—

A sheet of thin India-rubber one foot square. A piece of tape long enough to hold the testicle in position. A Davidson's syringe. Place the lower extremity of the testicle at a point in the rubber exquidistant from the four corners, then, enveloping the testicle in the rubber, tie above its upper extremity, reflect the rubber, bringing its four corners together. The nozzle of the syringe should then be inserted within the folds of rubber and firmly tied. By this means, a double envelope will be formed about the testicle, similar to the manner in which the pleura encloses the lung. By exerting intermittent pressure of the hand upon the bulb of the syringe, air will be forced into the sheet-sac, producing a uniform pressure over the whole surface of the enlarged testicle, which pressure may be controlled at the will of the operator and graduated to the condition of the organ.—Dr. James F. Ferguson, New York, in *Medical World.*

Importation of Powdered Drugs.—A few years ago a lot of rhubarb root was rejected at the New York Custom House as unfit for medicinal use. It appears that it was reshipped to Europe, powdered, and again sent to this country. It is well known how difficult it is to examine most powdered drugs and establish their purity by chemical assay or by the microscope, and it is a remarkable fact that powdered drugs which can be easily tested, particularly those containing alkaloids, are rarely if ever imported, while those the nature of which offers opportunities for sophistication or deception, are frequently sent here, often done up in packages without any clue as to the maker's name, and consigned to parties not in the drug business. Such circumstances in themselves create suspicion, and if it is remembered that in this country we have ample facilities for powdering drugs, equal to those of European countries, it must certainly be conceded that there exists no necessity for importing drugs in a pulverized condition.

An attempt recently made to import a quantity of powdered drugs, evidently sophisticated, offered a good opportunity to bring this important subject to the notice of the Treasury, the movement being aided by a number of prominent importers, druggists, pharmacists, and physicians. It is to be hoped that the Treasury regulations will be so altered as to exclude all powdered drugs, unless they be of such a nature that their quality can be easily determined. —*American Journal of Pharmacy.*

Cases of Ovariotomy.—Of the 100 cases of ovariotomy reported by Mr. Thomas Keith, of Edinburgh, 81 recovered. In the first 50 the mortality was 22 per cent.; in the last 50 it was only 16. He remarks that the larger portion of those who died were poor, worn-out women. If there had been an earlier operation in some of them, he says, the mortality would undoubtedly have been much lower.—*N. Y. Medical Record.*

Loyalty to Science.—The Paris Academy of Medicine have refused to strike off the names of their eminent German colleagues from the roll of members, as they have been commanded to do.—*Ibid.*

Medical Miscellany.

THOMAS HAWKES TANNER, M.D., F.L.S., M.R.C.P., died in Brighton, July 7th, at the early age of 46. He began practice in London in 1847, and since then had held several responsible appointments, and enjoyed for many years past a very extensive practice. His "Manual of the Practice of Medicine," originally published in 1854, has gained in popularity with each successive edition, and from a mere pocket manual has grown to a complete work in two large volumes. He was the author also of "Signs and Diseases of Pregnancy," a "Practical Treatise on the Diseases of Infancy and Childhood, "Clinical Medicine," an "Index of Diseases," "Memoranda on Poisons," and several smaller works and papers on various subject. The leading characteristic of his life was indomitable industry, which enabled him to accomplish a vast amount of work, though at the sacrifice of his own health. He had been suffering for several years from renal disease consequent on an attack of scarlet fever in 1854, and his death was caused by uræmia. For two months before his death he had been obliged to relinquish his professional duties.—*New York Medical Journal.*

STATISTICS OF THE GERMAN WAR.—The Central Bureau of Information in Berlin has published a report of its operations, from which it appears that the institution during twelve months had obtained authentic information of 633,000 sick and wounded soldiers, of whom 78,000 belonged to the French, and the remaining 555,000 to the German army. Of the latter, 46,000 belonged to South Germany, so that 500,000 cases may be allotted to the North German army. It is argued that these figures do not comprise all the cases of sickness, and that in making an allowance of 100,000 for the wounded, the number of unwounded sick can be placed at half a million persons.—*Med. and Surg. Reporter.*

OVERCROWDING IN LARGE TOWNS.—In the report of the health of Liverpool, just presented by Drs. Sanderson and Parkes, a tracing was given showing the arrangement of streets where 4,748 people were crowded into a space which did not exceed 23,500 square yards; or, the compression of the population nearly equalled 1,000 persons to an acre. Within the courts each house was usually found to consist of a room on the ground floor, a room above this, and a third room in the attic. Most of them have cellars. It happens very frequently that there is a family in each room except the cellar. In many cases the staircase forms a part of the rooms, and is without any window, so that there is an inevitable mixture of the air contained in all the rooms. Few constructions could be better adapted for the spread of contagious diseases.—*Dublin Med. Press & Cir.*

THE CALIFORNIA PHARMACEUTICAL ASSOCIATION, at its twenty-sixth meeting lately held in San Francisco, elected the following gentlemen as honorary members, the same having been approved by the Executive Committee:—Chas. A. Tufts, Dover, N. H.; Dr. E. R. Squibb, Brooklyn, N. Y.; Prof. E. Parrish, Philadelphia; S. M. Colcord, Boston; T. W. Metcalf, Boston.

BOOKS RECEIVED.—A Treatise on Localized Electrization, and its Application to Pathology and Therapeutics. By Dr. G. B. Duchenne. Translated by Herber Tibbits, M.D., Licentiate of the Royal College of Physicians of London. With numerous Illustrations, and Notes and Additions by the Translator. Philadelphia: Lindsay & Blakiston. Pp. 322.—Essay on Growths in the Larynx: with Reports, and an Analysis of one hundred consecutive Cases treated by the Author, &c. By Morell Mackenzie, M.D. Lond., M.R.C.P., Physician to the Hospital for Diseases of the Throat, &c. With numerous Illustrations in Chromo-lithography and Wood-engraving. Philadelphia: Lindsay & Blakiston. Pp. 263.—Restorative Medicine. An Harveian Annual Oration, delivered at the Royal College of Physicians, London, June 21, 1871. (The 210th Anniversary.) By Thomas King Chambers, M.D., &c. With two Sequels. Philadelphia: Henry C. Lea. Pp. 85. (The three above-named works are from A. Williams & Co., Boston.—Cancer; its Classification and Remedies. By J. W. Bright, M.D. Philadelphia: published by S. W. Butler, D.D. Pp. 191.

MARRIED,—In Charlestown, 5th inst, Edward Jacob Forster, M.D., to Miss Anita Damon, daughter of Henry Lyon, M.D., all of Charlestown.

DIED,—At Griggsville, Ill., Joseph B. Reynolds, late of Concord, Mass.

Deaths in seventeen Cities and Towns of Massachusetts for the week ending Sept. 2, 1871.

Cities and Towns.	*No. of Deaths.*
Boston	150
Charlestown	8
Worcester	20
Lowell	31
Milford	5
Chelsea	7
Cambridge	25
Salem	7
Lawrence	14
Springfield	5
Lynn	18
Gloucester	9
Fitchburg	5
Newburyport	6
Somerville	9
Fall River	16
Holyoke	3
	338

Prevalent Diseases.	
Cholera infantum	79
Consumption	49
Dysentery & Diarrhœa	17
Typhoid fever	14

Twelve persons died from smallpox; ten in Lowell, one in Boston, one in Holyoke. Eight deaths in Lynn were caused by the recent railroad accident at Revere.

GEORGE DERBY, M.D.,
Secretary of State Board of Health.

DEATHS IN BOSTON for the week ending Saturday, Sept. 2d, 150. Males, 57; females, 93. Accident, 4—apoplexy, 1—anæmia, 1—inflammation of the bowels, 3—bronchitis, 2—inflammation of the brain, 1—congestion the brain, 1—burned, 1—cancer, 3—cholera infantum, 39—cholera morbus, 2—consumption, 23—convulsions, 2—croup, 1—cyanosis, 1—debility, 5—diarrhœa, 6—dropsy, 1—dropsy of brain, 2—dysentery, 2—erysipelas, 1—scarlet fever, 2—typhoid fever, 7—gangrene, 2—gastritis, 1—disease of the heart, 3—hip disease, 1—icterus neonatorum, 1—intemperance, 1—disease of the kidneys, 2—disease of the liver, 3—inflammation of the lungs, 1—marasmus, 6—paralysis, 1—puerperal disease, 2—caries of the spine, 1—scalded, 2—smallpox, 1—syphilis, 2—tumor, 1—uræmia, 1—whooping cough, 2—unknown, 6.

Under 5 years of age, 71—between 5 and 20 years, 10—between 20 and 40 years, 36—between 40 and 60 years, 22—above 60 years, 11. Born in the United States, 106—Ireland, 33—other places, 11.